08/22/2008 07:23 FAX 2024429430

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		ALTH AND HUMAN SERVICES ARE & MEDICAID SERVICES				PRINTED: 08/23/A FORM APPROV OMB NO. 0938-0-
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED OSIGNO8
		09G094	B. WIN	۱G		08/67200
NAME OF F	PROVIDER OR SUF	'LIER		693	EET ADDRESS, CITY, STATE, ZIP CODE 34 9TH STREET, NW ASHINGTON, DC 20012	
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W 000	INITIAL CON	MENTS	W	000		
	August 6, 20 survey was in A random sa from a popul	on survey was conducted from 8 through August 7, 2008. The itiated using the full survey process, nple of two clients was selected ation of three male clients with ntal retardation and other various			GOVERNMENT OF THE DISTRIC DEPARTMENT OF HE HEALTH REGULATION ADM 825 NORTH CAPITOL ST., N.I.	CT OF COLUMBIA EALTH IINISTRATION E., 2ND FLOOR

W 114

The findings of the survey were based on observations at the group home and two day programs, in erviews with clients and staff, and the review of clinical and administrative records including inclient reports.

483.410(c)(4 CLIENT RECORDS

Any individu: I v/ho makes an entry in a client's record must nake it legibly, date it, and sign it.

This STAND AR.D is not met as evidenced by: Based on int in iew and record review, the facility failed to ensi re that all personnel making entries into the clien's records were signed for one of the two clients in duded in the sample. (Client #1)

The finding i cludes:

The facility's Registered Nurse (RN) failed to sign Client #1's q arterly reviews,

Interview wit the facility's Licensed Practical Nurse (LPN) on August 6, 2008 at at approximate / 3:00 PM revealed that the RN completed quarterly nursing examinations. Review of th : Client #1's medical record revealed two nursing - uarterly reviews, completed on February 22 2008 and May 22, 2008 that were not signed.

The QMRP will ensure that the RN Supe visor signs all nursing quarterly reviews.

WASHINGTON, D.C. 20002

LABORATORY DIRECTOR'S OF PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE

program participation.

Any deficiency statement and ng with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 elecfollowing the date of survey will ether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclossable and days following the date these locuments are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued a

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DEPARTMENT OF HE ALTH AND HUMAN SERVICES

PRINTED: 08/22/2 FORM APPRO

	SEOD MEDI		& MEDICAID SERVICES				OMB NO. 0938-035
STATEMENT	OF DEFICIENCIES F CORRECTION	<u> </u>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		LE CONSTRUCTION	((3) DATE SURVEY COMPLETED
			09G094	B. WII	۱G''''		08/07/2008
NAME OF P	ROVIDER OR SUF	 ²LIER			69	EET ADDRESS, CITY, STATE, ZIP CODE 34 9TH STREET, NW ASHINGTON, DC 20012	
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W 120	The facility in meet the need. This STAND Based on observed, the facility in the finding is the finding in the finding is the finding in the finding is the finding in the finding is the findicated that the Upon requesion for Client restriction procedure for the finding is the findicated that the Upon requesion for Client for Client for Client for Client for the finding is the findicated that the Upon requesion for Client for the finding for Client for Client for the finding	URC ust as as as of the collider observed the Coord of call the Co	is not met as evidenced by: is not met as evidenced by: is not met as evid	W		The QMRP will train the day program client's fluid restrictions and monitor implementation.	
			diet order of 1800 calorie, low	}			

FORM CMS-2567(02-99) Previous Versions Obsolete

1500 cc fluid restriction diet.

fat, low chole sterol, low sodium, low fiber, and a

The 1500 cc fluid restriction for Client #1 should be provided as follows:

Event ID: D3GF11

Facility ID: 09G094

If continuation sheet Page 3

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2004

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARD SERVICES

PRINTED 08/22/0 FORM APPROV OMB NO 0838-1

STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION		\$	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ULTIPLE LD:NG	CONSTRUCTION	X3) DATE SURVE / COMPLETED		
			09G094	a. Win	1G		08/07/2008		
NAME OF P	PROVIDER OR SU) 05	PLIER			6934	T ADDRESS, CITY, STATE, ZIP CODE 4 9TH STREET, NW SHINGTON, DC 20012!			
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W 120	Continued F	orn pa	age 2	W 1	120				
•	During breal should recei ounces);	fast, l e two	unch and dinner, Client #1 , four ounces of liquids (8						
	During medi day), Client i water (12 ou	1 sho	administration (three times per uld receive four ounces of and						
	During snactounces of flu		Client #1 should receive four						
i	implemented	eyide Clien	ence that the day program staff t #1's fluid restriction protocol				9 / 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2		
W 124	as ordered. 483.420(a)(2 RIGHTS) PRC	TECTION OF CLIENTS	W 1	124				
	Therefore the parent (if the of the client's and behavious)	: facili cl ent medi ai sta	nsure the rights of all clients. ty must inform each client, is a minor), or legal guardian, cal condition, developmental tus, attendant risks of ne right to refuse treatment.						
	Based on ob review, the fi would ensure risks and bea	ci.ity f ci.ity f c ient elits c	is not met as evidenced by: ion, staff interview, and record ailed to establish a system that is that were informed of their of their medication for two of e sample, (Clients #1 and #2)			,			
	The findings	nclud	e:						
	2008 at 8:30	AM, th	ance conference on August 6, ne House Manager revealed ved psychotropic medications	•	pr tre	The QMRP will ensure that the client' covides written, informed consent for an eatments recommended prior to such treeing implemented.	medical /6/2/26		

08/22/2008 07:24 FAX 2024429430

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDI MARE & MEDICAID SERVICES

PRINTED: (68/22/2 FORM APPROV (-0938-0)

	OF DEFICIENCIE OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION	(3) DATE SURVEY COMPLETED	
NAME OF P	ROVIDER OR SUF	09G094	6:	REET ADDRESS, CITY, STATE, ZIP COD 934 9TH STREET, NW VASHINGTON, DC 20012	08/07/2008 ODE	
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W 124	for behaviora the medicatic observed rec 3 mg. Revie orders revea three times r 100 mg and record verific was incorpor Plan (BSP) c targeted beh physical agg absconding, motivated we Interview wit approximate brother was the client's lepsychologica that the clien decisions on planning, restreatment an psychotropic record dated idenitifed the	management. At 4:40 PM, during n observation, Client #1 was siving Buspar 10 mg and Risperdal v of the client's current physician at that the client received Buspar ar day, Risperdal twice a day, Atarax (anax 3 mg at bedtime. Further ation indicated that the medication ated into the client Behavior Support ated June 7, 2008 to address wiors that included verbal and assion, non-compliance, ittiffing, loud talking and behaviorally tting. The QMRP on August 6, 2008 at 7, 0:00 AM revealed that Client #1's ery involved in his life but was not gal guardian. Review of the client's, assessment at 1:21 PM revealed did not have the ability to make his own behalf regarding habilitation dential placement, finances, I medical matters. There was a medication consent in the client's November 1, 2007. The consent following medications and dosages:	W 124			
	- Xanax XR ;	•	,			
	- Buspar 5 m - Risperdal 1	mg QAM and 3 mg QPM; and				
	- Atarax 100	_			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
:	client's broth	documented evidence that the rivas made aware of the increased nedication dosages.				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/22/2003 FORM APPROVED OMB NO. 0938-0391

CENTE	42 FOR MED	CAKE	& MEDICAID SERVICES			<u>OMB NO.</u>	0938-05
	F OF DEFICIENCE OF CORRECTION	3	(X1) FROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MULTIPI A. BUILD:NG	LE CONSTRUCTION	X3) DATE SL COMPLE	
			09G094	B, WING		0879	772008
NAME OF P	ROVIDER OR SU D 05	PLIER		693	ET ADDRESS, CITY, STATE, ZIP CODE 34 9TH STREET, NW ASHINGTON, DC 20012	L	
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W 124	Continued F	orn pa	ge 4	W 124			
	medication pand was adr 1 mg. Review orders reveated the Ativan three day. Intervisa pproximate was prescrib management revealed tha into Client #2 address targ	ass on inister / of the ed that imies p / with / 5:00 ad their the m s BSF ateid be on-co	served during the evening August 6, 2008 at 4:48 PM ed Ativan 1 mg and Risperdal e client current physician's t the client was prescribed per day and Risperdal twice a the medication nurse at PM revealed that the client se medications for behavioral her interview with the LPN edications were incorporated dated February 11, 2008, to ehaviors that included Verbal mpliance, obsconding and pehaviors.		2. See response to #1 above.		10/2/08
	10:00 AM re- involved in h guardians. F psychologica revealed tha- make decisic habilitation p finances, tre- was no docu informed Clie and risks of t	eatled a life be eview assess the clins on anning traent nented at #2's eatme	MRP on August 6, 2008 at that Client #2's mother was ut was not the client's legal of the Client #2's, sement dated July 7, 2007, ent did not have the ability to his behalf regarding, residential placement, and medical matters. There is evidence that the facility mother of the health benefits ent associated with the use of edications and corresponding		•		
	on August 6, Ativan 2 mg Record verifi continuing ph	2008 a ills in a ation r ysician	ntrol substances medications it 5:10 PM revealed two a blister package for Client #2. revealed a current and its order dated May 29, 2008 pam (Ativan) 2 mg (2 tab)		3. See response to # 1 above.	/ 6,	12/08

FORM CMS-2567(02-99) Provious rersions Obsolets

take one tablet now, if not calm in one hour,

Event ID; D3GF11

Facility ID: 09G094

If continuation she there is a

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICALD SERVICES

STATEMENT OF DEFICIENCI AND PLAN OF CORRECTION					(ULTI	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF 5	200 (0000 000 000		09G094	B. WI			08/07/2 008		
CARECO	ROVIDER OR SU) 05	.bijek		STREET ADDRESS, CITY, STATE, ZIP C 6934 9TH STREET, NW WASHINGTON, DC 20012					
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W 140	Interview with August 7, 20 revealed that consulting with medical receipted a and May 29. Interview with revealed the facility in health beneficially with the use 483.420(b)(**	n the constant the mass to make the mass to make the mass to make the mass or make the mas	om page 5 me for anxiety. I the designated nurse (LPN) on DE at approximately 10:00 AM the medication was only given after th the Psychiatrist. Review of the rds to include physician orders on revealed that the medication was id given twice on March 25, 2008 2008 respectively. I the QMRP and record verification is was no documented evidence that formed Client #2's mother of the its and risks of treatment associated of Ativan on an as need basis. I (i) CLIENT FINANCES			The QMRP will maintain receipts and o	of er proofs		
	that assures clients' persibehalf of clie This STANE Based on int facility failed system had complete ac funds, for on sample. (Cl. The finding interview wit Professional financial reciapproximate	a full a nat fur nts. AFLD is riview to proveish e ounting of the ant #2) cludes the C (C-MR) rds on / 11:00				that justify the client's expenditures from community account.	m his /6/2/0		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FQ的协议PPR(CENTERS FOR MEDICARE & MEDICARD SERVICES STATEMENT OF DEFICIENCI: S (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G094 08/07/2008 NAME OF PROVIDER OR SU 'PLIER STREET ADDRESS. CITY, STATE, ZIP CODE 6934 9TH STREET, NW CARECO 05 WASHINGTON, DC 20012 SUMN RY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECT ON (EACH DE IC ENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOLLD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LIST IDENTIFYING INFORMATION) TAG DEFICIENCY) W 140 | Continued F orn page 6 W 140 Continued ir :erview and record review revealed that the clier traceived Supplemental Security Income (SS in the amount of \$70.00 monthly. Further review of the client's record revealed a withdrawal ir the amount of \$30.00 on April 3, 2008. At the time of the survey, the facility falled to provide er idence that justified the withdrawals from Client # 2's personal account. W 192 483.430(e)(1) STAFF TRAINING PROGRAM W 192 For employe as who work with clients, training See response to W 120 above. must focus (n skills and competencies directed toward clien 3' nealth needs. This STANE ARD is not met as evidenced by: Based on ot servation, staff interview and record verification, the facility failed to demonstrate competency in implementing clients water fluid restriction to one of the two clients included in the sample. (Client #1) The finding I cludes: On August 6 2008 at 8:20 PM, Client #1 was observed tall nij a brown bag lunch to his day program. In arview with the direct care staff indicated tha the client was on a "special diet." Upon reques; the direct care staff provided a diet plan for Clier t#1. The diet plan revealed a fluid restriction protocol. The protocol consisted of a 1500 cc fluid restriction. On August 6 2008 at approximately 12:10 PM, Client #1 wa observed having lunch and drinking a 16.9 ounce bottle of water. Interview with the Qualified Mental Retardation

FORM CMS-2567(02-99) Previous /ersions Obsolete

Professional QMRP) and Licensed Practical

Event ID: D3GF11

Facility ID: 09G094

If continuation sheet Page

DEPARTMENT OF HE (LTH AND HUMAN SERVICES

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FORM CMS-2567(02-99) Previous Persions Obsolete

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FRINTED: 08/22/2006 FORM APPROVED CMB NO: 0938-035

CENTER	S FOR MEDIC	AIRE	& MEDICAID SERVICES				C WR NO. 0838-000		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				(X2) M	ULTIF	LE CONSTRUCTION	(K X) DATE SOLVEY COMPACTORS		
AND PLAN O	CORRECTION		IDENTIFICATION NUMBER:	A. BUI	LDING	<u> </u>		150	
			09G094	B. WI	√G		08/07/2008	 	
NAME OF P	ROVIDER OR SUPI	JE:R			l	EET ADDRESS, CITY, STATE, ZIP CODE			
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				7	\ \\	ASHINGTON, DC 20012			
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W 192	Continued Fr	m pa	age 7	W	192				
ĺ	Nurse (LPN) approximately was on a 180	200rd 10:0	dinator on August 7, 2008 at 00 AM revealed that the client orie, low sodlum, fluid eview of the current physician				TATELLE SAFERI SAFERICA		
	orders reveal	d a tero	diet order of 1800 calorie, low i, low sodium, low fiber, and a			·		1000	
	be provided a	llot a		(i					
			unch and dinner, Client #1 , four ounces of liquids (8				estiment of the Control of	:	
		siho	administration (three times per ould receive four ounces of and	: :					
	During snack ounces of flu		, Client #1 should receive four						
			ence that the day program staff it #1's fluid restriction protocol				State Control		
W 227	483.440(c)(4)	IND	IVIDUAL PROGRAM PLAN	w	227				
	objectives ne as identified I	essay the	gram plan states the specific ary to meet the client's needs, comprehensive assessment aph (c)(3) of this section.			The QMRP will develop and implement management program for the client.	t a money /6/2/6	8	
	Based on ob- and record re an objective	erva /iew /as c	is not met as evidenced by: tion, client and staff, interview , the facility falled to ensure that leveloped to address clients ent training need as identified in						

Event ID: D3GF11

Facility ID: 09G094

If continuation sheet Page (800).

FORM CMS-2567(02-99) Previous en:lons Obsolete

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DEPARTMENT OF HE ALTH AND HUMAN SERVICES CENTERS FOR MEDI 2: RE & MEDICAID SERVICES

PRINTED: 08/22/2003 FORM APPROVE OMB NO: 0938-039

	t of deficiencie of correction	(X1) PROVIDER/SUPPLIER/CLIA ICENTIFICATION NUMBER:	A. BUII	ULTIPLE CONSTRUCTION LDING	(3) DATE SURVEY COMPLETED
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W 227	Clients includ The finding ir On August 6, the surveyor his day progr Later on the sobserved tak indicated that Interview with Professional approximatel received a standard interview a standard interview the check is to	nsive assessment for one of the two d in the sample. (Client #1) cludes: 2008 at 7:45 AM, Client #1 informed not he performed janitorial task at in and received a payroll check, arne day, at 4:00 PM, Client #1 was ng a dollar from his pocket, and his cousin gave him the money. the Qualified Mental Retardation QMRP) on August 7, 2008 at 3:00 PM revealed that Client #1 pend check from his day program, ev with the QMRP indicated that aken to the corporate office and he company's finance department, money skills assessment dated 2007 indicated that the client from money management training	W 2	227	
W 249	not reflect a " 483.440(d)(1 As soon as the formulated an each client metreatment prointerventions and frequence.	Ps, reviewed on August 7, 2008 did purchasing program" objective. PROGRAM IMPLEMENTATION a interdisciplinary team has elient's individual program plan, ist receive a continuous active gram consisting of needed and services in sufficient number to support the achievement of the ntified in the individual program	W 2	49	

Event ID: D3GF11

Facility ID: 09G094

If continuation sheet Page (8.)

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MED CARE & MEDICAID SERVICES

PRINT關係: 08/20/2008 FORM APPROVED OMB NO. 0938-0

STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION		3	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1	IULTIPI ILD NG	LE CONSTRUCTION	X3) DATE SURVEY COMPLETED		
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	Based on int failed to ensuinterdisciplin program plan active treatmand frequence objectives ideplan (IPP), for (Clients #1 a The findings 1. The facilit in their self-in programs fast During the mon August 6, nurse was obmedication from the client. The midentifing the client what we replied, "for moderated that medication indicated that medication indicated that medication planterview with Coordinator of Client #1 part program, to medicated, "[the cadministration active to administration interview of the cadministration i	AFID inview re that ry teach and seach and sea	s not met as evidenced by: and record review, the facility t as soon as the m formulated client's individual client received continuous rvices, in sufficient number apport the achievement of the l in the Individual Program of the two clients in the facility. It to ensure clients participated ion administration training	W:		1. The QMRP will ensure that the medinurses, LPN Coordinator and RN Super made aware of and trained on correct implementation of the client's self-mediprogram.	v sor are		

FORM CMS-2567(02-99) Previous * ersions Obsolete

Event ID: 03GF11

Facility ID: 09G094

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 08/22/2000 FORM APPROVIDE OMB NO. 0938-939.

STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION		E (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IULT'I	PLE CONSTRUCTION	((3) DATE SURVEY COMPLETED			
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(X4) ID PREFIX TAG	(EACH DEF	DIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	UID BE	COMPLETIONS FACE		
W 249	as followed: - client aware - washes har - client gets of the control of the con	of the dath of the cation evide ing to dinner the cliental final had rehouse servatine final had be all fina	e time for medication pass; proughly water; dication; diosage from container; and in mouth. ence that the medication nurse the Client #1 that addressed er observation on August 6, tely 6:00 PM, Client #2 was tures on. Interview with the 1008 at approximately 4:22 PM ient had a program to take is. Review of Client #2's IPP at 11:45AM revealed a ent to complete the steps ain his dentures. The program we days per week and use manager was to be also per week. Review of the collection sheet revealed that not been collected from August is manager acknowledged intation. Ition, staff interview, and accility failed to ensure that been collected in accordance Program Plan (IPP) for one of e sample. (Client #2)	W:	249	2. See response to #1 above. The QMF review the data at least weekly to ensure properly collected on the IPP.	F will	is /0/2/08		
	1. During the	dinne	r observation on August 6.			1. See response to #2 above		10/2/08		

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DEPARTMENT OF HI A_TH AND HUMAN SERVICES CENTERS FOR MED CARE & MEDICAID SERVICES

PRINTED: 08/22/20 FORM APPROVI DMB NO. 0938-03

	OF DEFICIENCIE F CORRECTION	;	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	X3) DATE: COMPL		
			09G094	e. Wir	NG	· · · · · · · · · · · · · · · · · · ·	08/	07/20 00:	
NAME OF PROVIDER OR SU CARECO 05		PL ER		· · 	6	REET ADDRESS, CITY, STATE, ZIP CODE 934 9TH STREET, NW VASHINGTON, DC 20012	AN WHITE AND THE AND T		
(X4) ID PREFIX TAG	(EACH DEF	CLENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX ·	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DU DBE 🦠	(VAV)	
	observed we staff on Augi revealed tha care of his don August 7, program for for the dentu five days per manager wa week. Revie sheet reveal collected from manager acidocumentation. Client #2 medication p. The nurse program how for which the sauce. The to the client, program how for which the 1. Get water 2. Ask nurse 3. Give nam 4. Repeat question 5. Take mec 6. Drink water 4t no time du	ix main and a ring of the client of the clie	dely 6:00 PM, Client #2 was dentures on. Interview with the 2:008 at approximately 4:22 PM ient had a program to take s. Review of Client #2's IPP at 11:45AM revealed a ent to complete steps in caring the program was implemented and according to the house adocumented five days per the August 2:008 data collection approgram data had not been ust 2-6, 2:008. The house dged the lack of the client's medication for buring the liquid medication in the pills from the blister pack, and mixing the pills in apple then spoon fed the medication wof the self-medication revealed that the follwing step should have followed: I to nurse; edication; and	W	249	2. The QMRP will ensure that the me nurses implement the self-medication written.	lication P!'as	10/2/08	
	3. The facilit	failed	to implement Client #1's new			3. The QMRP will ensure that staff are implement the meal preparation IPP as	tr tined and	10/2/08	

2014

DEPARTMENT OF HI ALTH AND HUMAN SERVICES
CENTERS FOR MEDICALD SERVICES

PRINTED: 108/22/00 FORM APPROVE DMB NO. 0938-01

	F CORRECTION	1	IDENTIFICATION NUMBER;	A. BUI		G	COMPLETED
			09G094	B, Wil	۰, DI		08/07/2003
NAME OF PROVIDER OR SUI		PL ER			6	REET ADDRESS. CITY, STATE. ZIP CODE 934 9TH STREET, NW VASHINGTON, DC 20012 :	
(X4) ID PREFIX TAG	(EACH DEF	CHENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN DF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULDBE - FOOWPLER OF
W 249	Team (IDT): Individual Suburing evenistaff was ob: #1's snack a went on a cc 6:00 PM, the 6:35 PM, stathe dishwash taking out the Review of the revealed a posterior of the program of the committed in the committed in the opinion client protect. This STAND Based on intracility failed	ig objected and according to a short according to a	mended by the Interdisciplinary Idressed in the client's Plan (ISP) meeting. Servation on August 6, 2007, I to prepare and provide Client ner. At 4:45 PM, Client #1 nity walk for 25 minutes. At received his dinner plate. At observed to put the dishes in pe the counter tops and stove, in and relining the trash can. Idated December 12, 2007, In objective that stated, "Given the client's will plan and prepare a consecutive months." Review the ection of data the program had at since the client's ISP OGRAM MONITORING & December 12, 2007, and other programs that, as committee, involve risks to	-	249	The QMRP will ensure that the FIRC reclient's BSP and medications to control	views the behaviors.
	Committee (I sample. (Cli-	lRC) nis#	for two of two clients in the 1 and 非2)				
							117(94)

FRINTED: 08/22/2 FORM APPROVE DEPARTMENT OF HE ALTH AND HUMAN SERVICES OMB NO. 0938 0 CENTERS FOR MEDI: :ARE & MEDICAID SERVICES C 3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 08/07/2008 09G094 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUP "LIER 6934 9TH STREET, NW CARECO 05 WASHINGTON, DC 20012 PROVIDER'S PLAN OF CORRECTION SUMMY RY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (X4) (D PREFIX (EACH DEF DIENCY MUST BE PRECEDED BY FULL (0.41) CROSS-REFERENCED TO THE APPRO 'RIATE PRÉFIX REGULATOR Y DR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) W 262 W 262 Continued From page 13 The facility falled to ensure that Client #1's Behavior Ma agement Plan (BMP) and psychotropic medications were reviewed, and approved by he HRC. During the el trance conference on August 6, 2008 at 8:30 AM, the House Manager revealed that Client #' received psychotropic medications for behaviors management. At 4:40 PM, during the medication observation, Client #1 was observed receiving Buspar 10 mg and Risperdal 3 mg. Revie v of the client's current physician orders revea acithat the client received Buspar three times par day, Risperdal twice a day, Atarax 100 mg and (anax 3 mg at bedtime. Interview and the reco direview revealed the client had a behavior ma lagement plan (BMP) to address his targeted behaviors. Review of the BSP dated June 7, 2008 confirmed that the client has a current BMF to address his maladaptive behaviors of verbal and phyiscal aggression, non-complia ice, absconding, stuffing his pockets, loud talking initial inside and beahviorally motivated w tting. The review of the HRC minutes on / ugust 6 and 7, 2008, revealed that the HRC did not review the BMP's medications to control behavior. W 263 483,440(f)(3 (ii) PROGRAM MONITORING & W 263 The QMRP will ensure that the client's nedical CHANGE decision-maker provides written inform :d consent prior to implementation of recommende i restrictive The commit as should insure that these programs treatments designed to control behavior: are conduct donly with the written informed consent of the client, parents (if the client is a minor) or legal guardian.

FORM CMS-2567(02-98) Praviou. Versions Obsolete

This STANE ARD is not met as evidenced by:
Based on ol servation, staff interview and record
review, the aclity failed to ensure that each

Event ID: D3GF11

Facility ID: 09G094

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINT 08/22/20 FORM APPROVA OMB NO. 0938-05

STATEMENT OF DEFICIENCILS (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED. A. BUILDING B. WING 090094 08/07/2008 NAME OF PROVIDER OR SUI PLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6934 9TH STREET, NW CARECO 05 WASHINGTON, DC 20012 (X4) (D SUMM ARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECT ON PREFIX (EACH DE ICIENCY MUST BE PRECEDED BY FULL PREFIX EACH CORRECTIVE ACTION SHOULD BE COMPU REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W 263 Continued F orn page 14 W 263 client's behavior intervention technique, including the use of be havior modification drugs was conducted with the written informed consent of the client, parents (if the client is a minor) or legal guardian for one of the two clients in the sample. (Client #2) The finding includes: The facility filled to obtain informed consent prior to the use of restrictive measures as described in #2's Behavic : Support Plan. [See W124] W 295 483.450(d)(%(i) PHYSICAL RESTRAINTS W 295 The QMRP will provide the Behavior St ecialist The facility n ay employ physical restraint only as with all data describing the client's mala laptive an integral p irt of an individual program plan that behavior to ensure that the BSP and related IPPs is intended to less restrictive means of appropriately describe all interventions reeded. managing ar dieliminating the behavior for which the restraint sapplied. This STAND VF.D is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that physical restraint was not used unless it was a part of the individual program plan (IPP)/Behavior Support Plan (BSP) or one of the two clients in the sample. (Client #2) The finding is cludes: Client #2 was observed during the evening medication pliss on August 6, 2008 at 4:48 PM and was administered Ativan 1 mg and Risperdal

FORM CMS-2567(02-99) Previous 'erstons Obsoleto

1 mg. Reviev of the client current physician's orders revealed that the client was prescribed Ativan three: mes per day and Risperdal twice a day. Intervier / with the medication nurse at approximatel 5:00 PM revealed that the client

Event ID: 0sGF11

Facility ID: 09G094

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DEPARTMENT OF HE ALTH AND HUMAN SERVICES CENTERS FOR MEDI 24RE & MEDICAID SERVICES

PRINTED: 08/22/2 FORMAPPROV OMB NO 20938-0

	OF DEFICIENCIE F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL	DING	COMPGETED
		09G094	B. WIN	G	08/07/2008
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W 295	managemen revealed that into Client #2 address targ aggression, behavioral we Review of Colient had exphysical agg On June 7, 2 leave the hokicking and that "atter physically properties of the revidence into evidence	orn page 15 ad these medications for behavioral. Further interview with the LPN the medications were incorporated as BSP dated February 11, 2008 to sted behaviors that included verbal con-compliance, absconding and atting behaviors. erit #2's record revealed that the hibited the following incident of easion toward staff; DC8 the client was attempting to use. His behavior was described as thempting to bite. The staff indicated moting verbal intervention while eventing the client from leaving." clients behavior support plan failed my physical interventions to control appropriate behaviors.	W 2	295	
W 312	Professiona that physica facility or to aggressive i 483.450(e)(a Drugs used must be use client's indiv specifically telimination care employe This STAND Based on ot	the Qualified Mental retardation and House manager acknowledged y preventing the client to leave the actrect him when he is physically not incorporated in his BSP. DRUG USAGE or control of inappropriate behavior tonly as an integral part of the dual program plan that is directed wards the reduction of and eventual the behaviors for which the drugs the treatment of the drugs that the use of collective failed to ensure that the use of collections.	W	See response to W295 above.	10/2/08

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AND PLAN OF	CORRECTION		IDENTIFICATION NUMBER:	A. BUI	LDING	3 <u></u>		
			09G094	B. WII	иG		© 80	07/200 8
NAME OF PRO	OVIDER OR SUF	PLIER		<u> </u>		EET ADDRESS, CITY, STATE, ZIP CODE		
CARECO 0	15					934 9TH STREET, NW /ASHINGTON, DC 20012		
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W 312 (Continued Fr	oni pa	ge 16	W	312			
i i	ncorporated	n the	on medications were Individual Program Plan (IPP) Illients in the sample. (Client				*!	
	The finding in	ebı. İb	s:					
1	August 6, 20 mg pills in a verification re dated May 2! (2 tab) take (i8 at 4 dister veale , 2006 ne tat	rol substances medications on 5:10 PM revealed two Ativan 2 package for Client #2. Record d a current physician's order 8 for Lorazepam (Ativan) 2 mg blet now, if not calm in one me for anxiety.					
r r c t	August 7, 20 revealed that ner after con of the Physic revealed that	18 at a the m suiting art Or the m	lesignated nurse (LPN) on approximately 10:00 AM nedication was only given by with the Psychiatrist. Review ders on the same day nedication was prescribed and May 29, 2008				ä	
	a behavior si aggression, i behavioral w	pport on-co tting.	QMRP indicated the client had plan which addressed verbal ompliance, absconding and The BSP did not address the inage the client's anxiety.		1			
t i W 331	that the use in his IPP/Be 483,460(c) N	f this navior JRSII	2's record failed to evidence medication was incorporated Support Plan.	w	331	The RN Supervisor will ensure that the	fi cilîty ha	
: - ₅	The facility π services in a	ust pr corda	ovide clients with nursing ance with their needs.			physicians orders before medications are administered.		10/2/08

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DEPARTMENT OF FEALTH AND HUMAN SERVICES CENTERS FOR MELICARE & MEDICAID SERVICES

PRINTED: 08/22/20/ FORM APPROVE OMB NO. 0938-034

	T OF DEFICIENCE OF CORRECTION	s	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL	JI.TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	(EACH DE	TOLENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	JD PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOLLD BE GOMPLETERS
W 331	This STANE Based on in facility's nur (PO's) for a	ARD i arview e failed nedica o clien	s not met as evidenced by: and record review, the d to have a physician's order ition prior to administering it for ts in the sample. (Client #2)	. W3	31	
W 385	2008 at app entry on the record for C correspondi record. Inte 2008 at app Urologist's c medication is was adminis Care Physic medication I she indicate however she obtain an orthe medicati 483.460(I)(3 RECORDKE The facility r and disposit This STANE Based on ot verification, of the receip	oximate July 20 or 250 g PO's view woximate fice can the plant the plant that the acknown of the EPING ust maximo of all the terms of all the facility and discrete facility and	's medical record on August 7, eiy 12:30 AM revealed an 108 medication administration or mg; however, there was no a for the medication in the 10:30 AM revealed that the 10:30 AM revealed the 10:30 AM revealed to 10:30 AM revealed that the 10:	W 3	The Director of Disability Services was a system for receipt and disposition of medications is produced; that nursing trained on the system; and that the system consistently implemented.	fal controlled stafare

FORM CMS-2567(02-99) Previous Versions Obsolets

Event ID: D3GF11

Facility ID: 09G094

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DEPARTMENT OF HE ALTH AND HUMAN SERVICES
CENTERS FOR MEDI: ARE & MEDICAID SERVICES

FRINTED: 08/22/2009 FORM APPROVIDE CMB NO. 0938-039

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING	(2.3) DATE SURVEY COMPLETED
	1	09G094	B. WING)	08/07/2008
NAME OF P	ROVIDER OR SUP	LHER		STREET ADDRESS, CITY, STATE, ZIP CO 6934 9TH STREET, NW WASHINGTON, DC 20012	A Company of the Comp
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W 385	receipt and d prescribed for An inspection August 6, 200 package that package labe Ativan 2 mg. Interview with indicated that manage the explosive beliverified by the receive this not to receive " one (1) hour record reflect	ell to provide evidence of the aposition of Ativan 2 mg tablets	W 38	35	
W 440 _.	Interview with falled to evide Ativan that we nor was there disposition of 483.470(i)(1) The facility or quarterly for This STAND Based on interaction of the faciled to hold	the RN and the review of records noe a record of the receipt of the is located in the medication cabinet, a system for the receipt and all controlled drugs. EVACUATION DRILLS ust hold evacuation drills at least ach shift of personnel. RD is not met as evidenced by: rview and record review, the facility evacuation drills at least quarterly of personnel.	W 4	The QMRP will ensure that all fire per regulations; the QMRP will endrills are properly documented.	e drills take place sure that fire

FORM CMS-2587(02-99) Previous /ersions Obsalets

Event ID: D3GF11

Facility ID: 09G094

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTÉD: 08/22/05 FORM APPROVE OMB NO. 0938-05

	OF DEFICIENCI F CORRECTION	S		IDER/SUPPLIER/CLIA TIFICATION NUMBER:	A. BUILDIN		(X3) DATE SUF COMPLETE	
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W 440	Continued F	nio.	page 19		W 440			
	The finding	ncluc	les:				6.1	
	Professiona August 6, 20	and 08⊩at	review of approxim	Mental Retardation he staff pattern on ately 2:00 PM Jule staffing pattern:				
	Sunday - Şa 7:00 AM - 3 3:00 PM -11 11:00 PM -	00 Pi	Ń; 'M; and		1			Alexander Alexander
	staff was re- on each shift revealed that	uired . Re :the	to conduction to the facility fail	MRP revealed that the ct one drill per month e fire drill log book ed to hold evacuation ach shift as evidenced				
	a. The last shift was Ma			:00 AM - 3:00 PM			. As .	
	b. The last shift was Ja			3:00 PM ~ 11:00 PM				
,	c. The last shift was Ma			1:00 PM - 7:00 AM			: :	
	The Qualifie	i [/le	ntal Retar o quarterly	dation Professional fire drills.				
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R 000	INITIAL COL	IMEN	ITS	ĺ	R 000		
R 125	2008 throug initiated usir sample of ty population or mental retar. The findings observation programs, in the review of including including including including including in all jurisdic employee o	Aug the president of the at the tervise clinic dent CGRO back pry of ker folions continued to the continued	was conducted from ust 7, 2008. The survey full survey process. A idents was selected from male residents with a and various other discrete group home and two east with residents and call and administrative reports. DUND CHECK REQUISITION CHECK SHALL discrete grevious seven within which the prospective worker has worker seven (7) years prior	rey was A random from a moderate sabilities. on o day d staff, and records UREMENT sclose the oyee or (7) years, pective ed or		The HR Director will ensure that crimi background checks are completed for i per regulations.	n il la sility staff
	Based on the failed to endisclosed the employee of seven (7) yethe prospect worked or into the chect. The finding Review of the revealed the failed to the chect.	e reviure c e crim cont ars, i tive e sided molud ie pe g GHI	rsonnel files on Augus MRP falled to provide	IMRP necks ospective evious in which vorker has years prior st 7, 2008 evidence			
legith Pos	of criminal staff (Staff ulation Administr	iackg 3).	round checks for one	direct care			
	ulation Administr USA 20 5		Manyon			TITLE	(X,3) USFYS
LABORATO	CON PC V	r © R⊇RO	VIOER/SUPPLIER REPRESE	ENTATIVE'S SI	GNATURE	Virector of Disability &	as a/2/18
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STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	ERICLIA MBER:	(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION	0.3) DATE SURVEY COMPLETED 08/07/2008
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PRINTED: 08/22/2007

STATEMENT OF DEFICIENCE IS (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD03-0145 08/07/2008 NAME OF PROVIDER OR SU PLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6934 9TH STREET, NW CARECO 05 WASHINGTON, DC 20012 SUMM RY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECT ON (EACH CORRECTIVE ACTION SHOULD BE (EACH DEL CLENCY MUST BE PRECEDED BY FULL PREFIX REGULATO (Y OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG [14] DEFICIENCY) 1000 INITIAL COMMENTS 1000 A licensure sur/ey was conducted from August 6, 2008 through August 7, 2008. The survey was initiated usin the full survey process. A random sample of two residents was selected from a population of three male residents with moderate mental retarc ation and various other disabilities. The findings of the survey were based on observations at the group home and two day programs, in arviews with residents and staff, and the review of plinical and administrative records including inci ent reports. 1 189 3508.7 ADMI NISTRATIVE SUPPORT 1189 See response to federal deficiency W140. Each GHMRI shall maintain records of residents ' funds received and disbursed. This Statute is not met as evidenced by: Based on interview and the record review, the GHMRP faile to provide evidence that assured a system had been established that maintained a complete accounting of each clients' personal funds, for one of the two residents included in the sample. (Res dent #2) The finding in :ludes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the GHMRP's financial recoi is on August 7, 2008, at approximately 11:00 AM revealed that the GHMRP a sisted Resident #2 with maintaining his finances. Continued interview and record review revealed that the client received Supr emental Security Income (SSI) in the amount of \$70.00 monthly. Further review of the client's record revealed a withdrawal in the amount of \$30 00 on April 3, 2008. At the time of Health Regulation Administratic Health Regulation Administratic I

Market H. Limpson

LABORATORY DIRECTOR'S OR FREVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE STATE FORM f continuation sh

PRINTED: 08/22/2007 FORM APPROVIDE

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	the survey, the that justified personal acc	1€ Wit	lity failed to provide e hdrawals from Resid	vidence ent #2's			
1 206	3509.6 PER	ONN	EL POLICIES	ĺ	1 206	· ·	
	annually ther certification to performed ar	eafter, al a h dichat	or to employment an shall provide a physlealth inventory has be the employee's heather to perform the re-	cian ' s een alth status		The HR Director will ensure that all pe employed in the facility have current h certificates per regulation.	
	Based on inte facility failed	tv ews	met as evidenced by s and record review, t are that four (4) of its	the i			
 	consultant sta inventories as	ff prov requi ealth	vided copies of currer red by State regulation (22 DCMR Chapter 3	ons I			
	The finding in	aludes	:				
	of personnel time there wa staff (Staff #1 Physician and	ecords ino e and # Phan	agency conducted as on August 7, 2008, vidence that two directions, the Primary Carection acist and two Licent deurrent health certif	at which ct care	;		
1 224	3510.5(a) ST.	FF T	RAINING		1224		
	Each training limited to, the	οπόgra fo lowi	ım shall include, but ı ing:	not be		The Director of Disability Services will a staff are trained in an overview of menta retardation.	or sure that 10/2/08
ealth Regula TATE FORM	ition Administratic	<u> </u>		G.B.		3GF11	lf continue (for singe)

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PRINTED: 08/22/2009 FORM APPROVE

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	not limited to retardation, a frequently us of individuals living skills;	definitions definition of the second definitio	ntal retardation includ tion, causes of ment ted health implication dications, the history nental retardation, an	al ns, and of care d daily		·		
	Based on rec	and rev	met as evidenced by view, the GHMRP fai verveiw of mental ret	led to				
:	The finding in	cludes	: :	-				
	revealed that	the Gl	ng records on Augus HMRP failed to provid of mental retardation	de			· :	
1 225	3510.5(b) ST	AFF TO	RAINING		1 225			
	Each training limited to, the	progra follow	am shall include, but ing:	not be		The Director of Disability Services will estaff are trained in Human Development.		10/2/08
	(b) Human de (birth to deatl	velopr);	nent through the life	cycle				
	Based on rec	ard rev	met as evidenced by: riew, the GHMRP fail provide to each staf	ed to	ı		:	
!	The finding in	aludes	:			•		
	Review of the revealed that training in Hu	he GF	ig records on August IMRP failed to provid evelopment.	7, 2008 le				
I 227	3510.5(d) ST.	FF TF	RAINING		1 227	The RN Supervisor will ensure that staff	f are trained	
İ	Each training	orogra	m shall include, but r	not be		in infection control.		10/2/08
ealth Regula	ntion Administratio	ົ່າ		600	<u></u>	3GF11		وسرون مارسور والمراجع والمراع والمراجع والمراجع والمراجع والمراجع والمراجع والمراجع والمراجع

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	<u> </u>							
	T OF DEFICIENCE OF CORRECTION	s	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	R/CLIA MBER:	(X2) MULTI	PLE CONSTRUCTION		DATE SURVEY COMPLETED
			HFD03-0145		B, WING			08/07/2003
NAME OF P	ROVIDER OR SUI	PLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CARECO	05				STREET, NO STON, DC 20			
(X4) ID PREFIX TAG	(EACH DEI	CIENC	ATEMENT OF DEFICIENCIE OY MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE , DEFICIENCY)	SHOU D B	E COMPLETE
1 227	Continued F	orn p	age 3		1227			
	limited to, the	follo	wing:					
	(c) Infection	ontro	ol for staff and residen	ts;				
	This Statute	is no	t met as evidenced by	r.				
I 229	3510.5(f) ST	₹ F -	TRAINING		1 229			
ļ	Each training limited to, the	prog follo	gram shall include, but owing:	not be	,	See response to federal deficience	y W1 2.	10/2/68
, ;	residents to to, behavior	ie se nama tal co	related to the GHMRI rved including, but not gement, sexuality, nut ommunications, and as	limited rition,				
į	Based on int GHMRP fails and compets accordance	anviewed to a nt to with the cf the	It met as evidenced by wand record review, the ensure that all staff we provide assistance in the Individual Support in the	ne ere trained Plan				
	The finding i	ıclude	es:					
	observed tal program. In indicated the Upon reques plan for Clies	ng a srviev the c titl stoco	B at 8:20 PM, Client #1 brown bag lunch to hi w with the direct care so client was on a "special direct care staff provident The diet plan revealed. The protocol consistiction.	s day staff al diet." ded a diet d a fluid				
	On August 6 Client #1 wa allon Administra	: cbse	3 at approximately 12: erved having lunch an	10 PM, d drinking				

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08/22/2008 FRI 19:34 [TX/RX NO 5749]

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	TOF DEFICIENCIE: DE CORRECTION	IDENTIFICATION	NUMBER:	A. BUILDIN B. WING	- · · · · · · · · · · · · · · ·	() 3) DATE SURVEY COMPLET (E)
		HFD03-014		DESS CITY S	STATE, ZIP CODE	08/07/2008
CARECC	ROVIDER OR SUPI	LIER	6934 9TH	STREET, N' STON, DC 2	w	
(X4) ID PREFIX TAG	(EACH DEFI	Y STATEMENT OF DEFICIENT IE NOY MUST BE PRECEDED OF LISC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLIBE :: COMPLOY:
1 229	Continued Fro	m page 4		1 229		1 m 1 m 1 m
	a 16.9 ounce	poltle of water.	•			
. •	Professional (Nurse (LPN) approximately was on a 180 restriction die	the Qualified Mental R QMRP) and Licensed coordinator on August 10:00 AM revealed th calorie, low sodium, f Review of the currer d a diet order of 1800	Practical 7, 2008 at at the client iluid it physician			
	fat, low chole:	terol, low sodium, low estriction diet.				
	The 1500 cc i be provided a	uid restriction for Clier i follows:	nt #1 should			same at the first of the first
		ist, lunch and dinner, the two, four ounces of the				
	During medic day), Client# water (12 our	tion administration (the should receive four o ses); and	ree times per unces of			
	During snack ounces of flui	tinne, Client #1 should I.	receive four			
	There was no implemented as ordered.	evidence that the day Dilent #1's fluid restrict	program staff tion protocol			
I 291	3514.2 RESII	ENT RECORDS		I 291	TANKARIU)	
		nall be kept current, da n individual who make			See response to federal deficiency W	15/2/08
Liable D	Based on rec ensure each the individual of the two res	s not met as evidence rd review the GHMRF esidents records were completing the assess dents in the the sample	railed to signed by ment for one			
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ND PLAN	IT OF DEFICIENCIE OF CORRECTION		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA MBÉR:	A. BUILDII		COMPLETED
NAME OF F	PROVIDER OR SUPI		HFD03-0145		B. WING	08/07/2006	
CARECO		LIER		6934 9TH	DORESS, CITY, I STREET, N STON, DC 2	RECTION (X)	
(X4) ID PREFIX TAG	ı (EACH DEFI	SUMMA Y STATEMENT OF DEFICIENCIES CHIDEFI IENCY MUST BE PRECEDED BY FULL ULATOR 'CR LSC IDENTIFYING INFORMATION)		S	ID PREFIX TAG		
1 291	Continued Fro	n pa	ge 5	·	l 291		- Maria di Angara di
	The finding in:	ludes	s :				A
	The facility's F Resident #1's	∌g iste Įuarte	ered Nurse (RN) faile erly reviews.	ed to aign			
	nurse (LPN) c approximately completed quarthe Resident # nursing quarte February 22, 2 quarterly revie	1 Aug 3:00 I rterly I's m ly rev 008 a vs ho	cility's Licensed Practicust 6, 2008 at lat PM revealed that the nursing exams. Revealed tracer revealed the second revealed the second may 22, 2008. The wever were not signs ompleted the quarter	RN View of ed two d on he			
1 420	3521.1 HABILI	[A]TIC	ON AND TRAINING	ļ	l 420		MARKA (1772) (17. H)
	training to its n and maintain the more effective environments :	sider ose li vvith n(! to	provide habilitation a nts to enable them to ife skills needed to o the demands of thei achieve their optimund ad social functioning	acquire ope r		See response to federal deficiency W	227. /0/z/
, 1 2 1 1 0 1	Based on obseive on the GH and training to them to acquire cope with their toptimum levels	Vatio //RP :s res and anviro of ph	net as evidenced by: n, interview and reco failed to provide habi idents that would en- maintain life skills ne priments and achieve hysical, mental and si f the two reisdents in 2)	litation able eded to			
	The findings in⊟		•			•	
h Regular	On August 6, 2	0.3 at	7:45 AM, Client #1				

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STATEMENT OF DEFICIENCE S (X1) FROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD03-0145 08/07/2008 NAME OF PROVIDER OR SUI PLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6934 9TH STREET, NW CARECO 05 WASHINGTON, DC 20012 SUMM, RY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECT ON מו PRÉFIX (EACH DEF CHENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOU .D BE REGULATO .Y DR LSC IDENTIFYING INFORMATION) COMO TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 1420 Continued From page 6 1420 informed the surveyor that he performed janitorial task at his day program and received a payroll check. Later or the same day, at 4:00 PM, Client #1 was obse ved taking a dollar from his pocket, and indicated that his cousin gave him the money. Interview with the Qualified Mental Retardation Professional QMRP) on August 7, 2008 at approximatel 3:00 PM revealed that Client #1 received a st pend check from his day program. Further interview with the QMRP indicated that the check is taken to the corporate office and deposited by he company's finance department. Review of the money skills assessment dated November 27 2007 indicated that the client would benefit from money management training (purchasing r togram). The client's IF Ps, reviewed on August 7, 2008 did not reflect a " iurchasing program" objective. 1 422 3521.3 HABILITATION AND TRAINING 1422 See response to federal deficiency W249. Each GHMRF shall provide habilitation, training and assistance to residents in accordance with the resident ' : Individual Habilitation Plan. This Statute : not met as evidenced by: Based on inte view and record review, the GHMRP failer to provide training and assistance to residents in accordance with the their Individual Hat litation Plans for one of the two residents included in the sample. (Residents #1 and #2) The findings is clude: The facility failed to ensure clients participated. in their self-midication administration training Health Regulation Administratio STATE FORM D3GF11 If continuation sheet ?

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STATEMENT OF DEFICIENCES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD03-0145 08/07/2008 NAME OF PROVIDER OR SU 'PLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6934 9TH STREET, NW CAREÇO 05 WASHINGTON, DC 20012 SUMN IRY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECT ON (EACH DE ICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LISC IDENTIFYING INFORMATION) COMPLYIS TAG TAG CROSS-REFERENCED TO THE APPRIJERIATE DEFICIENCY) Continued F orn page 7 1422 1422 programs fa evidenced below: During the maclication administration observation on August 6, 2008 at 4:40 PM, the medication nurse was o served to punch Client #1's medication for the blister package, pour the water, give tile medication cup and water to the client. The riedication nurse was overheard identifing the medications (Buspar) asking the client what was the medication used. The client replied, "for my behaviors." The client was observed to independently consumer the medication. Interview with the medication nurse indicated the the client participated in a self medication program to name his medication. Interview wit the Licensed Practical Nurse (LPN) Coordinator in August 7, 2008 indicated that Client #1 par ic pates in a self medication program, to I ame the vitamin pill, three times per week. Revie v of the client's Individual Program Plan (IPP), hawever revealed an objective which stated, "[the lient] will participate in medication administration by completing the steps necessary to take his medication." The training steps were as followed: client aware of the time for medication pass; - washes har its thoroughly - client gets cur of water; - identifies ov n medication: - removes cc rect dosage from container; and - placed med cation in mouth. There was no evidence that the medication nurse provided trait ing to the Client #1 that addressed the objective During the dinner observation on August 6, 2008 at appn ximately 6:00 PM, Client #2 was observed with dentures on. Interview with the Health Regulation Administration STATE FORM

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STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING		X3) DATE SURVEY COMPLETED	
			HFD03-0145		B. WING _	<u>.</u> .	08/07/2003
NAME OF PI	ROVIDER OR SU	PLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE	I00/01/2006
CARECO 05		6934 9TH		STREET, NW STON, DG 20012			
(X4) ID PREFIX TAG	(EACH DEI	RY STATEMENT OF DEFICIENCIES I CIENCY MUST BE PRECEDED BY FULL IY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	LLD BE COMPLETE	
1 422	Continued F	orn page 8			1422		
	staff on Augrevealed that care of his don August 7, program for necessary in was implemented according to documented August 2008 program dat 2-6, 2008. If the lack of documented according to documented August 2008 program dat 2-6, 2008 for the lack of documented according to the lack of documented according to the lack of documented according to the lack of documented according to the lack of documented according to the lack of documented according to the lack of the la	is st 6, 2008 at approximately 4:22 PM at the client had a program to take dimitures. Review of Client #2's IPP 2008 at 11:45AM revealed a her client to complete the steps maintain his dentures. The program need five days per week and the house manager was to be five days per week. Review of the data collection sheet revealed that the house manager acknowledged incumentation. It is servation, staff interview, and the facility failed to ensure that the house manager acknowledged in the facility failed to ensure that the house manager had been collected in accordance in its in the sample. (Client #2)		1 722			
	2008 at approbserved we staff on Augrevealed that care of his don August 7 program for for the dentufive days permanager was week. Reviewsheet reveal collected from an ager acidocumentatics	cinne eximat aring c st 6, 2 the clientures 2008 a he clies. The worth worth at that a Augunowled	er observation on Aug rely 6:00 PM, Client # lentures on. Interview 1008 at approximately lent had a program to s. Review of Client # at 11:45AM revealed and to complete steps ne program was imple and according to the documented five day le August 2008 data in program data had no program data had no let 2-6, 2008. The had diged the lack of	2 was w with the y 4:22 PM take 2's IPP a in caring emented house ys per collection ot been ouse			
	tion Administra		naerven anting the 6/	vening			

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	T OF DEFICIENC OF CORRECTION	is	(X1) FROVIDER/SUPPLIE IDENTIFICATION NU HFD03-0145		(X2) MULTIF A. BUILDING B. WING	PLE CONSTRUCTION	(X5) DATE SURVEY COMPLETED
NAME OF P	ROVIDER OR SU	PLIER	111 200-0140	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	08/07/2005
CARECO 05		6934 971		6934 9TH	STREET, NW STON, DC 20012		
(X4) ID PREFIX TAG	(EACH DE	RY STATEMENT OF DEFICIENCIES CICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENCY	ON SHOLLD BE HE APPR)PRIATE
1 422	medication The nurse p administration the cup, ren crushing the sauce. The to the client program hor for which the 1. Get water 2. Ask nurs 3. Give nar 4. Repeat c 5. Take me 6. Drink wa At no time c observation through 4 or 3. The facil program as Team (IDT) Individual S During ever staff was ot #1's snack of went on a c 6:00 PM, th 6:35 PM, stathe dishwas	asis or epareen by poving the policy of the	n August 6, 2008 at 4 d the client's medical ouring the liquid mediche pills from the blished mixing the pills in then spoon fed the mow of the self-medical revealed that the followed to nurse; edication; hedication; and he medication passed client implement stop of the color of the self-medication; and the medication passed client implement stop our medication passed client implement stop our medication passed client implement stop our medication passed client implement stop our medication passed client implement stop our medication passed client implement stop our medication passed client implement stop our medication passed client implement stop our medication passed client implement stop our medication passed client implement stop our medication passed client implement stop our medication passed the pills in	tion for dication in ter pack, apple nedication tion wing step di: t #1's new disciplinary is de Client ent #1 es. At clate. At dishes in and stove.	1 422		
	Review of the revealed and verbal promisimple mea of the programme.	e IPP or rogram ots, [the for six im, colle	dated December 12, nobjective that stated eclient] will plan and consecutive months ection of data the pro-	2007, d, "Given prepare a ." Review			
leaith Regul STATE FOR	ation Administra M	io r		 1	1800 D:	3GF11	If continuation sheet, notes to

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STATEMEN AND PLAN	IT OF DEFICIENC OF CORRECTION	IDENTIFICATION NUMBER:			(X2) MULT A, BUILDII B, WING		(X3) DATE SURVEY COMMENTARY
HFD03-0145				_i		08/07/2008	
						STATE, ZIP CODE	
CARECO 05 6934 9" WASHII			6934 9TH S WASHINGT	TON, DC 2	VW 20012		
(X4) ID PREFIX TAG	(EACH DE	IC ENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE
I 422	Continued F	orn page 10			1 422		
	not been implementing.	lemen	t since the client's IS	Р			
1 500	3523.1 RES	DIENT	S RIGHTS		1 500		
Each GHMF be residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, the chapter, and other applicable District and federal laws.				and 2-137, this			
	Based on ot review, the (servation HMRF htts wei	met as evidenced by on, interview and rec failed to ensure ead re observed and prot deral Laws.	ord			
İ	The findings	nolude	£				
	would ensure their risks ar	Feside a liene	led to establish a sys ents that were inform fits of their medicatio Report Citations W12	ed of on. (See		See responses to federal deficiencies with the window win	√124 and 10/2/68
	assured a sy maintained a resident's pe	RP failed to provide evidence that starm had been established that complete accounting of each assumate funds. (See Federal Sport Citation W140)				2. See response to federal deficiency W	140. 10/2/08
	the interdisci individual pro continuous a number and achievement Individual Pro	ilinary gram p :tive tre requer of the c gram F	ed to ensure that as a team formulated clied lan, each client recestant services, in a copy to support the objectives Identified in Plan. (See Federal Etation W249)	nt's ived sufficient	,	3. See response to federal deficiency W	249. <i>18/2/08</i>
	ition Administrat			<u>. </u>		<u> </u>	
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STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			R/CLIA MBER:	(X2) MULT A. BUILDIN B. WING	(:3) DATE SURVE COMPLETED				
			HFD03-0145				08/07/2008		
NAME OF P	ROVIDER OR SUP	LLER		l		STATE, ZIP CODE			
CARECO 05 6934 97 WASHII					I STREET, NW GTON, DC 20012				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEF DIENCY MUST BE PRECEDED BY FULL REGULATOLY OR LSC IDENTIFYING INFORMATION)			FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE		
1 500	Continued Fram page 11				1 500	•			
	measures ha	l beei ittee.	iled to ensure that re n approved by the Hi (See Federal Defici :62)	uman		4. See response to federal deficiency V	N2 62. /6/2/08		
	,					·			
							İ		
Health Regul STATE FOR	ation Administra M	on			899	J D3GF11	If continuistion singl		